

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
MEDICAL ASSISTANCE ADMINISTRATION  
Olympia, Washington**

**To:** Pharmacies  
All Prescribers  
Managed Care Plans  
Nursing Home Administrators

**Memorandum No: 05-01 MAA**  
**Issued:** January 3, 2004

**From:** Douglas Porter, Assistant Secretary  
Medical Assistance Administration

**For More Information, call:**  
1-800-562-6188

**Subject: Prescription Drug Program: Expedited Prior Authorization Updates**

**Effective the week of February 7, 2005, and after,** the Medical Assistance Administration (MAA) will implement the changes to expedited prior authorization codes and criteria for MAA's Prescription Drug Program outlined in this memorandum.

**Changes to Expedited Prior Authorization Codes and Criteria**

<b>Drug</b>	<b>Code</b>	<b>Criteria</b>
<b>Enbrel®</b> ( <i>etanercept</i> )	017	Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD).
	024	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more DMARD.
	025	Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Dose not to exceed 50mg subcutaneously twice weekly for the first three months of therapy and not to exceed 50mg weekly thereafter.

**Billing Instructions Replacement Pages**

Attached are replacement pages H.9-H.10 for MAA's current *Prescription Drug Program Billing Instructions*.

## How can I get MAA's provider issuances?

To obtain MAA's provider numbered memoranda and billing instructions, go to MAA's website at <http://maa.dshs.wa.gov> (click on the Billing Instructions/Numbered Memoranda or Provider Publications/Fee Schedules link).

To request a free hard copy from the Department of Printing:

- **Go to:** <http://www.prt.wa.gov/> (Orders filled daily)  
Click on General Store. Follow prompts to Store Lobby → Search by Agency → Department of Social and Health Services → Medical Assistance Administration → desired issuance; **or**
- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX (360) 586-6361/  
telephone (360) 586-6360. (Orders may take up to 2 weeks to fill.)

## Prescription Drug Program

Drug	Code	Criteria
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<b>Duragesic®</b> (fentanyl)	040	Diagnosis of cancer-related pain.
<b>Enbrel®</b> (etanercept)	017	Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist up to <b>50mg subcutaneously per week</b> for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD).
	024	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist up to <b>50mg subcutaneously per week</b> for patients who have had an inadequate response to one or more DMARD.
	025	Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Dose not to exceed 50mg subcutaneously twice weekly for the first three months of therapy and not to exceed 50mg weekly thereafter.
<b>Fazaclo®</b> (clozapine)	012	All of the following must apply: <ul style="list-style-type: none"> <li>a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and</li> <li>b) Patient is 18 years of age or older; and</li> <li>c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above; and</li> <li>d) Must have tried and failed generic clozapine.</li> </ul>
<b>Focalin®</b> (dexamethylphenidate HCl)		See criteria for Concerta®.

Drug	Code	Criteria
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<b>Geodon®</b> (ziprasidone HCl)	046	All of the following must apply: <ul style="list-style-type: none"> <li>a) There must be an appropriate DSM IV diagnosis; and</li> <li>b) Patient is 6 years of age or older.</li> </ul>
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**Note:** Because Geodon® prolongs the QT interval (< Seroquel® > Risperdal® > Zyprexa®), it is contraindicated in patients with a known history of QT prolongation (including a congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval.

<b>Glycolax Powder®</b> (polyethylene glycol)	021	Treatment of occasional constipation. Must have tried and failed a less costly alternative.
<b>Humira Injection®</b> (adalimumab)	028	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients who have tried and failed one or more DMARD. Dose not to exceed 40mg subcutaneously every two weeks if patient is also receiving methotrexate, or up to 40mg subcutaneously every week if patient is not receiving methotrexate concomitantly.
<b>Infergen®</b> (interferon alfacon-1)	134	Treatment of chronic hepatitis C in patients 18 years of age and older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.
<b>Intron A®</b> (interferon alpha-2b recombinant)	030	Diagnosis of hairy cell leukemia in patients 18 years of age and older.
	031	Diagnosis of recurring or refractory condyloma acuminata (external genital/perianal area) for intralesional treatment in patients 18 years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients 18 years of age and older.

## Prescription Drug Program

Drug	Code	Criteria
	033	Diagnosis of chronic hepatitis B in patients 1 year of age and older.
	107	Diagnosis of malignant melanoma in patients 18 years of age and older.
	109	Treatment of chronic hepatitis C in patients 18 years of age and older.
	135	Diagnosis of follicular non-Hodgkin's lymphoma in patients 18 years of age and older.
<b>Kadian®</b> (morphine sulfate)	040	Diagnosis of cancer-related pain.
<b>Kineret Injection®</b> (anakinra)	029	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients 18 years of age and older who have tried and failed one or more DMARD. Daily dose not to exceed 100mg subcutaneously.
<b>Kytril®</b> (granisetron HCl)	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.
<b>Lamisil®</b> (terbinafine HCl)		Treatment of onychomycosis for up to 12 months per nail is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis and requiring systemic antibiotic therapy; <u>or</u>
	045	Fingernail involvement with or without chronic paronychia.
<b>Levorphanol</b>	040	Diagnosis of cancer-related pain.

Drug	Code	Criteria
<b>Lotrel®</b> (amlodipine besylate/benazepril)	038	Treatment of hypertension as a second line agent when blood pressure is not controlled by any: <ul style="list-style-type: none"> <li>a) ACE inhibitor alone; <u>or</u></li> <li>b) Calcium channel blocker alone; <u>or</u></li> <li>c) ACE inhibitor and a calcium channel blocker as two separate concomitant prescriptions.</li> </ul>
<b>Marinol®</b> (dronabinol)	035	Diagnosis of cachexia associated with AIDS
	036	Diagnosis of cancer and failure of all other drugs to adequately treat nausea and vomiting related to radiation or chemotherapy.
<b>Metadate CD®</b> (methylphenidate HCl)		See criteria for Concerta®.
<b>Miralax®</b> (polyethylene glycol)		See criteria for Glycolax Powder®
<b>Naltrexone</b>		See criteria for ReVia®.
<b>Nephrocaps®</b>	096	Treatment of patients with renal disease.
<b>Nephro-FER®</b> (ferrous fumarate/ folic acid)		
<b>Nephro-Vite®</b> Vitamin B comp W-C)		
<b>Nephro-Vite RX®</b> (folic acid/vitamin B comp W-C)		
<b>Nephro-Vite+FE®</b> (fe fumarate/FA/ vitamin B comp W-C)		
<b>Nephron FA®</b> (fe fumarate/doss/ FA/B comp & C)		